

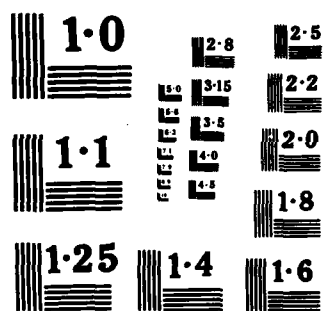
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piecemeal and counterproductive unless the framework of a master strategy is formulated and applied by all concerned. History reveals that the purpose of military medicine is to conserve the human ingredient of combat power. It is, in modern terms, a combat multiplier. The strategy for supporting that purpose should emphasize the importance of medical forces; quality, versatile professionals; flexible medical forces; prevention of disease and injury; and health care operations that complement military operations and objectives. Such strategy will serve to perpetuate a long tradition of military medical excellence, bring competing factions together and result in improved quality health care operations well into the next century.

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USAWC MILITARY STUDIES PROGRAM PAPER

IN SEARCH OF MILITARY MEDICAL STRATEGY

INDIVIDUAL ESSAY

by

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US Army War College
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ABSTRACT

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The armed services medical departments are under severe, open criticism from both the Department of Defense and the private sector. Substantive action is required to correct glaring deficiencies in two major areas—medical force readiness and quality health care. There is, however, no fully articulated strategy for developing and executing corrective actions. Furthermore, a polarity between "quality health care" and "force readiness" professionals of the medical departments has resulted in severe competition for scarce resources. As a result, it is likely that without a strategy, medical programs will be piecemeal and counterproductive unless the framework of a master strategy is formulated and applied by all concerned. History reveals that the purpose of military medicine is to conserve the human ingredient of combat power. It is, in modern terms, a "combat multiplier." The strategy for supporting that purpose should emphasize the importance of medical forces; quality, versatile professionals; flexible medical forces; prevention of disease and injury; and health care operations that complement military operations and objectives. Such a strategy will serve to perpetuate a long tradition of military medical excellence, bring competing factions together and result in improved quality health care operations well into the next century.

INTRODUCTION

For over 200 years, the medical departments of the Army and Navy, and more recently the Air Force, have been at the forefront of American men of medicine in the progress of the art and science of medicine around the world.¹ Today, these formerly separate departments serve jointly under the Department of Defense which operates the world's largest military medical system. Together they comprise 688 hospitals and clinics, 142,000 personnel and a budget exceeding \$9 billion a year. Yet, in spite of a well deserved reputation for excellence and what would appear to be a generous fiscal endowment, there is a distinct possibility that at no time in the history of this nation have the medical services of the Armed Forces been more subject to such intense criticism. Deficiencies that had once been exclusively a subject of major concern and deliberate corrective action within the Department of Defense have now been vividly brought to the attention of the general public, evoking staunch outcries and pressures for reform.

The deficiencies in question fall into two general categories, either of which could have a seriously degrading effect on the readiness of the United States to employ its military forces in support of its vital national interests and objectives. First is the concern that our wartime wounded might not receive adequate care due to serious force readiness deficiencies in combat training for medical personnel and shortages of deployable medical units.² A second concern further suggests that there are "scandalous levels of malpractice, cover-up and corruption" in the medical services.^{3,4,5} If these concerns are valid, then not only do we have ill prepared and too few medical

forces, but the ones that we do have may be ethically and professionally incompetent!

There are ample facts to substantiate both allegations and to date, no officials of the Armed Forces have argued that these damning facts are incorrect. Some within the Department of Defense have argued that the degree of unpreparedness and technical incompetence might have been unfairly amplified in some accounts, but virtually all agree that these two salient problems exist and must be corrected. And so it would seem that if these allegations are correct, it is simply a matter of identification of the source of the deficiencies and establishment of a careful scheme for their correction. But this is not entirely the case.

The fact is that the real controversy has not yet begun on this issue and will not likely erupt between a troubled public and the military establishment. Neither will the Army, Navy, and Air Force argue among themselves to any degree that will impede progress toward a solution to the problems. The most debilitating arguments are more likely to occur within the medical staffs of each service on how these deficiencies are to be corrected and whether quality health care or force readiness will receive priority of attention and resources.

In fact, there is no commonly accepted strategy and no universally accepted, unifying purpose within the military health care community that will lead to a resolution. This is perhaps the most serious problem of all. Divisiveness and lack of strategy combine to form the real disease and the problems that have recently been brought to the attention of the public are merely some of its symptoms. An examination of the root causes of this "disease" might yield some clues to its cure.

THE ROOTS OF CONTROVERSY

For at least the past two decades there has been a polarization between two powerful opposing forces in the medical establishment brought on by reductions in funding and manpower for defense, abandonment of the draft and consequent reductions in the deployable medical force structure. All but a thoughtful few fall exclusively into one camp or the other.

Each faction has its own eloquent spokesmen and loyal following. On the one hand we have those who believe that the exclusive foundation and purpose of military medicine is quality health care based upon scientific and technological excellence. For them the operative term in "military medicine" is "medicine." The other faction argues that, while quality health care is an indispensable ingredient to readiness and is in keeping with long established ethical codes of medical practice, the emphasis in military medicine should be on organizing, equipping and training deployable medical forces for support of the full spectrum of peacetime and especially wartime military operations. So while this recent public outcry has produced new general awareness of one of our nation's more serious defense problems, it has also quite unintentionally broadened the rift between these two opposing camps.

In the early 1960's, when there were sufficient resources, these factions never felt the pressure to openly compete. There was no reason for a civil war. They were simply two distinct groups content to thumb their noses at one another. Now, in the face of significant fiscal constraints, there is an open struggle for survival of each faction and both are clamoring for preeminence, each failing to recognize the contributions and general worth of the other.

In testimony before the House Appropriations Committee on 1 May 1984, Dr. William Meyer, Assistant Secretary of Defense for Health Affairs placed medical force readiness at the top of his list of past achievements and continued

future emphasis.⁶ His were comforting words for all who knew of the grave shortages of active Army units and medical equipment for the Reserve Components, whose units comprise nearly 70% of the deployable medical force. No doubt, medical planners and programmers in the Pentagon who helped prepare Dr. Meyer's testimony were pleased at the reactions of the House Appropriations Committee and the fiscal support that they subsequently received from their respective service staffs in preparation of the 1985 Defense Budget. Then on 15 January 1985, Secretary of Defense Casper Weinberger summoned the Surgeons General of the Armed Forces to a meeting of the Armed Forces Policy Council where they were enjoined to make quality health care their top priority and to take immediate action when problems occur. He was no doubt troubled by recent derogatory articles in The Army Times, Readers Digest, and The Washington Post, and he was perfectly correct in his admonition, but his words breathed new life into the quality health care "camp" and rekindled the controversy between the two opposing factions.

Medical force readiness or quality health care? Both require quality personnel and money for equipment, training and facility modernization. Unfortunately, as suggested earlier, there is no readily identifiable, unifying, fully-articulated strategy that will allow either of these two notions to coexist without debilitating the other. Rather than being mutually supportive as logic might suggest, the objectives of quality medicine and force readiness have become fiercely competitive. The expectations, demands and appetites of field commanders, soldiers and their dependents, and a growing retired population have frankly outstripped capabilities in both domains. Growing concern over the federal deficit and a general nationwide consensus that cuts in the Defense budget can help stem the tide of federal overspending are sure to mean that if improvements are to be made in military medicine, they must be made within some framework of strategy that inspires both prudent fiscal constraint

and mutually supportive medical department operations. But the only identifiable and operative medical "strategy", is one of open competition and salesmanship and this must change! Somehow, the military medical services must recapture some of the essence of former strategies and unified effort that have been the foundation of centuries of excellence.

A RETURN TO BASICS

Webster defines strategy as "a careful plan or method of action." It is not goals and objectives. It is action. Before formulating a strategy, however, it is useful and instructive (and some contend that it is essential) to define the purpose of the organization for which that strategy is intended. This is similar to the prominent position that the principle of "objective" has among the Principles of War. What is it that military medicine can achieve? If there were no medical services available to the military, would it matter?

The purpose or "objective" of medicine in general is clear to most but its fundamental purpose and ultimate objective with respect to its application to military art and practice has been lost in recent times. It thus requires us to examine history for an understanding of past relationships between medicine and the military. Perhaps there has always been a central purpose that may still apply today, and can aid in the development of a useful strategy to bring this most recent crisis to a peaceful and constructive conclusion—a conclusion that will be in the best interests of this nation and its armed forces.

The facts of history suggest that many armies have employed some form of health care, at least to the extent that the knowledge and skills of the day would allow, for the last 2000 years. The Roman Army was unique in this respect. It was the first regularly paid, professional, full-time army in the

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world. Its legions controlled frontier provinces and secured the fortunes of an entire empire for over 500 years. An indispensable component of the Roman military establishment was its medical contingent, with physicians and orderlies a part of the auxillary troops which accompanied each legion.⁷ Hospitals were also a central part of each permanent and temporary encampment. Moreover, that medical structure existed both in peacetime and wartime and there is little doubt that as a result the art and practice of military medicine advanced in the process. Clearly, there must have been some underlying reason for this deliberate application of medicine to the structure of the Roman Army.

If one examines the strategy of Rome, there emerges a striking similarity with the current national strategy of the United States.⁸ Rome's forces concentrated on securing the frontiers of its empire. In essence, so too are the military forces of the United States dedicated to protection of our global interests and geopolitical "frontiers." Rome depended on forward deployed forces and a central reserve that was trained and prepared to quickly move over its remarkable network of roads to shore up its defenses. Similarly the most prevalent elements of current US military strategy are the forward deployment of forces in areas of vital national interest, a strong and ready central reserve, and strategic mobility for purposes of reinforcement of forward deployed forces or application of force to other areas of interest. It seems then, that both the ancient Romans and the United States have placed a great deal of dependence on the armed forces to preserve their national interests and that the preservation and conservation of those forces has been of paramount importance. Perhaps the founders and sponsors of both the Roman and American armies also grew through experience to appreciate that medical services played a major role in that preservation process.

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It is doubtful that the thoughts of the Romans in this matter will ever be fully understood since their writings of the day do not discuss in detail the medical aspects of warfare. It is clear, however, that the ranks of their widely dispersed and vulnerable legions were kept reasonably full as a direct result of the healing arts. This is especially noteworthy in light of the state of the art of medicine in those days and the remote, hostile environments into which the legions were employed. But curiously the last 200 years of US military history have spawned some different perspectives on the role of medicine in military affairs.

While speculative philosophers are disputing about the origin of evil and the foundation of morals . . . the practical good man will endeavour to employ himself in alleviating those evils which he finds incident to human nature.

Surgeon John Jones, 1776.⁹

Thus began a special medical text by Surgeon John Jones of the Continental Army, encouraging his colleagues to turn their attentions from the causes and aims of the American Revolution and direct their energies to management of the special plight that it posed for the private soldier. Dr. Jones was a physician, not a soldier. He saw little connection between military strategy and medicine. He posited that the Revolution would end soon in one way or the other and the outcome would certainly not be influenced in any way by his actions or those of his fellow physicians.

Carl von Clausewitz would be born four years after the American Revolution. He would mature and gain profound insights into the nature of war, yet many of those insights would remain obscure and irrelevant to the military physicians of his day. Based on his chapter on the "Purpose and Means of War" in Book One of On War, Clausewitz might have agreed with Dr. Jones that "the political purpose of war has no connection with war itself."¹⁰ He might also have agreed that once war begins, it is indeed practical to alleviate those evils

incident to human nature, but to what end? What, he might well have asked, is the ultimate purpose of military medicine? Is it to alleviate the pain and suffering of war only or is its purpose perhaps broader and more substantial or functional than Dr. Jones suggested?

Clausewitz contends that there are three broad elements of strategy in war and that one of these is destruction of the enemy's fighting forces. He further specifies that in order to be destroyed, any military force must be put into such a condition that they can no longer carry on the fight.¹¹ Although Clausewitz never directly mentioned medical services, his writings suggest that if asked directly, he might have contended that one role of any military medical establishment in any army would be that of maintaining the morale of soldiers and thus their psychological capability to carry on. He might have also hastened to add that a second and equally important role would be the application of the marvelous skills of medicine in conservation of as many soldiers as possible for continuation of the fight. In more modern terms Clausewitz would view military medicine as a valuable "force multiplier." For the relatively small military forces of the infant American Army in the days of the Revolution, and certainly as it was for the Romans is for and the relatively small present day United States forces, this would be a particularly useful notion. But as recently as World War II, Korea, and Vietnam, the luxury of time to muster a seemingly endless supply of manpower has prompted very few (if any) American military planners and strategists and especially few military medical thinkers to ponder practical ways and means of applying medical forces to military strategy.

Dr. Jones was partially correct. As a physician he had pledged to exercise all of his skills to ensure the alleviation of human suffering but he would leave the war and its outcome to others. He failed to understand, however, that the military physician has an additional and equally ethical

task. He must be prepared in peace and war to preserve the force he supports. He must prepare to ply his skills in the preservation of the highly trained and skilled manpower which is the very foundation of any successful army. Accepting that both quality health care and force readiness are inseparable and mutually supportive, then our next step must be to develop a strategy that will combine these two elements into a framework for action that will serve as a means of charting a deliberate course towards a substantive solution of our most recent challenge of building and maintaining a ready and proficient military health care force.

A PROPOSED STRATEGY

No doubt the notional strategy that follows will ignite initial strong reactions, but the intent is not to provoke argument or further widen the gap between competing factions within the medical departments. Hopefully this will provoke open and objective thought and stimulate further innovative, unconstrained proposals. Finally, it is not intended as an ultimate solution or a recipe for success. It is merely a point of departure for development of a more refined strategy that will ultimately provide a common reference point in designing an improved health care system for the Armed Forces of the United States.

To support an aim of conserving the human ingredient of combat power, the strategy for the service medical departments in the next two decades should include as a minimum the following mutually dependent elements or tenets.

- o Retain dedicated medical forces in the national defense structure.
- o Develop quality, versatile professionals.
- o Develop flexible medical forces.
- o Emphasize prevention of disease and injury.

- o Make health care indispensable component of military operations and objectives.

The discussions that follow will provide the rationale for each of these strategic elements.

Retain Dedicated Medical Forces In The Defense Structure

Anyone endorsing this element of medical strategy would be reluctant to support both the trends that have developed during the recent series of Functional Area Analyses directed by the Vice Chief of Staff of the Army and the even more controversial Army of Excellence initiatives. Given few other choices, however, many functional area proponents have seriously, though reluctantly, considered elimination of medical spaces from their organizations. While they might expect that somehow the medical forces could be provided from elsewhere, the manpower constraints that make this trend appealing are also operational on the size and flexibility of the medical forces themselves. Medical support is not a good candidate for such economy of force consideration. Military medical personnel are specifically trained to provide combat health care and it is neither reasonable nor fair to ask other specialists to shoulder that burden.

Recent US Army trends in emphasizing self aid and buddy aid are very reasonable and appealing, especially in view of the "fog of battle" that will prevail as a result of the developing doctrine of Air-Land Battle. But this must not be accepted as an ultimate solution. Emphasis on self-help is only designed to solve the ever-present problem of immediate battlefield resuscitation. It does not relieve the service medical departments from their ultimate responsibility to continue in their efforts to devise operational doctrine and design forces that are compatible with their mission of acquisition and definitive treatment of the wounded. That mission cannot be abrogated. Other

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branches of the services must have complete support from the medical services to retain their own organic medical capability so that they might have complete freedom of action to execute their combat tasks with complete confidence that the health services are prepared to accomplish theirs. This demands that the medical departments of all services take steps to assure that the evolution of health care doctrines and forces will underwrite the probability of success of all the other branches. This also demands that the medical departments of all the services develop quality personnel who appreciate their unique role in the maintenance of combat power. This leads to the next strategic precept.

Develop Quality, Versatile Professionals

The overarching notion here is that all members of the service medical departments are professionals. None has ascendancy over the other. Each medical specialty and department is interdependent and success for one is success for the other. In the evolution of the American system, however, this has not been apparent. Educational opportunities, training, assignments and experience levels are sharply different among the various medical branches and a "we/they" mentality has evolved. To curb this trend requires a total reexamination of policies that perpetuate a 'most favored status' for any particular specialist on the medical team. Some examples at this point might help clarify this element of the strategy.

If it is to continue to be the policy that physicians are to command in wartime those units which deal in direct patient care, then they must be prepared for that task by placing them in command of those units in peacetime. We should thus prepare them for this task by assigning them to leadership positions as early as possible in their careers. We must also seriously consider such actions as reinstating the Battalion Surgeon. Physicians should be allowed and encouraged to compete for company command. Nurses,

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veterinarians, dentists, and medical specialist officers should be afforded the same opportunities.

Selection for schools and advanced degree programs also requires review. If it is decided to expand opportunities for command and leadership to encompass all branches of the service medical departments, then consider all branches for the formal educational opportunities available.

Opportunities in advance degree programs also require examination. Admittedly, there is an appetizing array of advanced degree programs available to medical department personnel, but there are also serious shortcomings. Curiously, the medical departments have few formally trained foreign area specialists or other trained in strategic intelligence, force development, force integration and a host of other general military specialties. Political science, foreign relations and others also represent serious gaps in the menu of skills that would allow medical department personnel to qualify for positions throughout the Department of Defense in such areas as legislative liaison, defense attache duties, or faculty positions in the various DOD educational institution. If medical department personnel are to realize their full potential in the Armed Forces, they require the credentials that allow them to succeed in the branch immaterial domain that dominates the military system.

Develop Flexible Medical Forces

Quality individuals exclusively dedicated to the health care mission cannot alone serve the total medical needs of an Army, Navy or Air Force. This element of strategy emphasizes that individual skills must be assembled into organizations capable of providing the full array of healing arts to accommodate the full spectrum of peacetime and wartime requirements.

Many current health care organizations are not flexible. They have been built in many cases exclusively on either peacetime or wartime requirements

and few are capable of rapid uninterrupted transition from peace to war and vice versa. Furthermore, many combat medical support organizations, particularly in the Army forces, are structured for support of a general war in Europe of the sort that might have been fought two or more decades ago. These units are admittedly the subject of a current comprehensive Medical Systems Program Review headed by the US Army Academy of Health Sciences. Moreover, these modernized organizations evolving from that review will incorporate equipment that has been standardized for use by all of the services. But modernization and standardization alone are not sufficient. The units that evolve must be flexible enough to be successfully employed in the full spectrum of war. They must be as relevant and adaptable to "Low Intensity Conflict" as described in Army Field Manual 100-20 as they are to a general, conventional or nuclear war.

Peacetime health care organizations must be similarly flexible and this may be the most profoundly difficult challenge of all. Intense pressure to achieve and maintain civilian accreditation standards, a diversified population of servicemen and their dependents, and a growing population of retirees have all collaborated to create a network of health care activities that through little fault of their own are staffed for peacetime health care needs and are not readily capable of making the transition necessary for support of wartime mobilization. To correct this will require a concentrated, comprehensive effort by the directors of peacetime health care organizations to assess equally their wartime and peacetime requirements and eventually take action to achieve the necessary balance between quality care and wartime flexibility.

Emphasize Prevention

Much of the demand for health care in both peace and war can be prevented. This is especially true of peacetime. Had many of the present day retirees

had the benefit of the Army's recently developed programs of wellness and fitness, it is likely that many of them would be enjoying much healthier lives and would require much less sophisticated and costly maintenance at this point in their lives. Though these programs are new and their impact is not yet conclusive, it is almost certain that they are the most cost effective approach to yielding a much hardier population of soldiers, dependents and retirees in the years to come.

Our preparation for war demands an even more concentrated effort. Losses due to disease and nonbattle injury have always exceeded those from direct combat action and the challenge to the Research and Development community has never been greater. Their charters should continue to emphasize ways and means of preventing unnecessary loss of combat power.

In keeping with this element of strategy, however, it must be clear to all that even though such prevention programs as those described above are promising, they are not the exclusive domain of the health care professional. Commanders, leaders and managers in all walks of the military must be encouraged to shoulder the lion's share of the responsibility to ensure that prevention programs are institutionalized. This thought, then, leads to the final element of the strategy.

Medical Activities Must Complement Military Operations

Health care belongs to the military and not vice versa. The military forces are a major component of the national strategy of the United States and the military medical community is merely one of many means available to insure continued American military prominence. Some of the messages sent by the military medical community to their comrades-in-arms, however unintended they may be, would seem to refute this thesis.

In the Army, for example, the Medical Department has its own personnel system, manages its own system of logistics, flies its own helicopters, "stove pipes" its activities throughout the world and speaks a jargon that few "outsiders" comprehend. Though some of this may be practical and justifiable, the rest of the military community is left with the impression that "medics" are not joiners and are perfectly content to be left to their own devices.

The dangers of such an atmosphere are twofold. There may be some health care professionals that actually believe medicine is the center of the universe. Most of those are too far gone to save, but the development of our newer medical soldiers must be predicated on the understanding that their military uniform demands that they recognize their membership in the profession of arms. A second danger is that the "rest" of the Armed Forces may have abandoned all hope that the health care community is interested in being regarded as military professionals and have thus resigned themselves to pursuing their military activities without the benefit of valuable medical input. To correct this situation, the medical departments must seriously examine wherever possible the merits of a strategy that emphasizes integration of their activities with the overall objectives of the military services. To do otherwise will serve only to perpetuate this current atmosphere of mistrust and misunderstanding between the medical departments and the "line".

A FINAL NOTE

The intent of this article has not been to derogate the motives, achievements and aspirations of the service medical departments, nor has it been to suggest that struggles within the medical departments will persist or necessarily preclude any possibility for eventual reconciliation. The fundamental purpose has been to encourage all involved to stop for a moment, reflect on their origins, define their purpose, and agree on a plan of action in keeping

with the long-established traditions of the medical services. The five element strategy presented herein is merely one well-intentioned attempt to articulate a "careful plan or method of action." Others will hopefully follow.

At present, there is no such plan and there is a desperate need for one. Only with a "road map" of this sort will it be possible, in the face of everlastingly limited resources, to unify factions within medical departments and enable each service to progress into the next century with productive, proficient, and ready military health care systems that are prepared to do their part in guaranteeing the continued military prominence of the United States.

ENDNOTES

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